APPLICATION FOR A NON-RENEWABLE LIMITED SCOPE TEMPORARY MEDICAL PERMIT

State Form 26138 (R4 / 10-02)

Approved by State Board of Accounts, 2002

Your Social Security Number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

Health Professions Bureau
402 W. Washington St., Rm. 041
Indianapolis, IN 46204
Telephone: (317) 234-2060
www.in.gov/hpb

REQUIREMENTS AND INSTRUCTIONS TO THE APPLICANT

A. Mail completed application, along with items listed below, to the Health Professions Bureau:

1. ***FEE -*** *Submit the one hundred dollar ($100) fee made payable to the Health Professions Bureau. Fees are non-refundable and non-transferable.*
2. ***PHOTOGRAPH -*** *Attach one (1) passport type quality photograph of your self taken within the last eight weeks.*
3. ***PROOF OF GRADUATION -*** *You may submit proof of graduation by submitting one of the following documents:*

   (a) ***OFFICIAL TRANSCRIPT*** *An* ***official*** *transcript of grades from the medical / osteopathic school, showing degree has been conferred. Graduates of foreign medical schools must submit notarized copies of all subjects and grades (mark sheets). Include official translation if not in english. (SEE NOTARIZED COPY NOTE)*

   (b) ***DEGREE*** *A notarized copy of your medical / osteopathic degree. Include official translation if not in english. (SEE NOTARIZED COPY NOTE)*
4. ***PROOF OF CURRENT LICENSE -*** *Provide proof of current licensure in another state. A notarized copy of your current license (billfold license or pocketcard) which shows your license number and expiration date will be acceptable.*

PERMITS ARE NOT AVAILABLE ON A WALK-IN BASIS FROM THE BUREAU. NO EXCEPTIONS.

NOTE: A Non-Renewable, Limited Scope, Temporary Permit May be Issued to an Applicant Only Once. THIS PERMIT IS VALID FOR A NON-RENEWABLE PERIOD OF NO MORE THAN THIRTY (30) DAYS.

NOTARIZED COPY NOTE: Any notarized copy of an original document must have the notary public make a statement of the fact that the notary has seen the original document.

THE NON-RENEWABLE, LIMITED SCOPE, TEMPORARY MEDICAL PERMIT SHALL BE LIMITED TO A SPECIFIC ACTIVITY, FUNCTION, SERIES OF EVENTS OR PURPOSE, AND TO A SPECIFIC GEOGRAPHIC AREA WITHIN THE STATE, WHICH LIMITATIONS SHALL BE STATED ON THE FACE OF THE PERMIT. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO CONTACT THIS OFFICE.

OFFICE USE ONLY

Permit fee	Date fee paid *(month, day, year)*	Receipt number

Permit number	Permit issuance date *(month, day, year)*

Applicant
Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.

APPLICANT INFORMATION

Name of applicant	Social Security number

Address *(number and street or Rural Route number)*

City, state, ZIP code

Telephone number (*daytime*)	Date of birth (*month, day, year*)	Place of birth

E-mail address

SPECIFICATION AND IDENTIFICATION

Specify reasons for seeking this permit

Specify type, extent , and specilization medical services to be provided

Specify specific location and exact dates that the above services will be provided.

Location:	From:	To:

(Continued on reverse side)

Office address (number and street)	Telephone number
City, State, ZIP code	Resident telephone number

DOCTOR OF MEDICINE/ OSTEOPATHIC DEGREE GRANTED BY	
Name of school	Date of graduation
List all states where you hold, or have held a license to practice medicine	

If your answer is "Yes" to any of following, explain fully in a sworn affidavit, including all related details. Include the violation, location, date and dispositon. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state *(including Indiana)* or country?	☐ Yes ☐ No
3. Are you now, or have you ever been treated for a drug abuse or alcohol problem?	☐ Yes ☐ No
4. Have you ever been charged with drug addiction?	☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or *nolo contendere* to: A. A violation of any Federal, State of Local law related to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. To any offense, misdemeaner or felony in any state? *(Execpt for minor violations of traffic laws resulting in fines.)*	☐ Yes ☐ No ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of dicipline or limitations?	☐ Yes ☐ No
7. Have you ever been admonished, censored, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned, requested by the Bureau or any of its authorized representatives in connection with processing my application for a non-renewable limited scope temporary medical permit.

I hereby release the aforementioned persons, firms, officers, corporations, association, organization, and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	Date *(month, day, year)*